

# CALIFORNIA MEDI-CAL

HIPAA – EDI Health Care  
Eligibility, Coverage or Benefit Inquiry and Response

## HS 270 and HB 271 Transaction Sets

Eligibility Inquiry – 4010A1 Implementation Format  
Spend Down (SD) and SD Reversals – 4010 Standard Format  
Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format

Overview for Leased-Line (LL) and  
CICS Inter-System Communication (ISC) Submissions

- - - Companion Guide - - -

EDS for CA Medi-Cal  
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# Table of Contents

Revision History .....	1
Disclaimer .....	2
Introduction.....	3
HIPAA Overview .....	3
Companion Guides .....	3
Guide Objective.....	3
Relationship to HIPAA Implementation Guides .....	4
New Terminology.....	4
Final Authority .....	4
Third-Party Dial-Up and Leased-Line Network Transmission Protocol Instructions .....	5
System Testing.....	6
Provider/Submitter Testing Procedures .....	6
Data Specifications Overview.....	7
Purposes of Specifications .....	7
General Transaction Formatting Information.....	7
Data Elements .....	7
Segments .....	8
Loops.....	9
Excluded Data Elements and Segments .....	9
Complete Transaction Example .....	9
Delimiters and Terminators.....	9
Submitter Software Versions.....	9
Identification Card Standards and Check-Digit Algorithms .....	10
Provider Mail .....	10
Appendix A: AAA Segment Error Processor Table .....	11

# Revision History

Date	Page	Loop/ Txn	Segment/ Element ID	Segment Name	Data Element/Field Name (Industry)	Description
6/15/2004	N/A	N/A	N/A	N/A	N/A	First published.

# **Disclaimer**

## **Purpose of the ANSI ASC X12N 270/271 Eligibility Benefit Inquiry/Response Transactions Companion Guide**

This Companion Guide for the ANSI ASC X12N 270/271 transaction has been created for use in conjunction with the Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information. This Companion Guide contains data clarifications derived from specific business rules that apply exclusively to Medicaid processing for the California Medi-Cal Program of the State of California Health and Human Services Agency – Department of Health Services (DHS). This guide also includes useful information about sending and receiving data to and from DHS using Leased-Line (LL) and Customer Information Control System (CICS) Inter-System Communication (ISC) submissions. Submitters are advised that updates to the DHS Medi-Cal Companion Guides will be made on an ongoing basis. Submitters are therefore encouraged to check the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) often for updates to the Companion Guides.

# Introduction

## HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA, Title II) of 1996 require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans and employers. The provisions also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both DHS and its providers are HIPAA-covered entities.

## Companion Guides

Companion Guides are available to external entities (health plans, program contractors, providers, third party processors and billing services) to clarify information about HIPAA-compliant electronic interfaces with DHS. The following data specifications are included in this Companion Guide. All are available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov); click the "HIPAA Update" link, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link.

Eligibility, Coverage and Benefit Inquiry:

- HS/270 Eligibility Inquiry – 4010A1 Implementation Format
- HS/270 Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format
- HS/270 Spend Down (SD) and SD Reversals – 4010 Standard Format

Eligibility, Coverage and Benefit Response:

- HB/271 Eligibility Inquiry – 4010A1 Implementation Format
- HB/271 Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format
- HB/271 Spend Down (SD) and SD Reversals – 4010 Standard Format

The 270 transaction, which requests benefit eligibility information, will be submitted to DHS for processing. DHS validates submission of ASC X12N format(s). If the file contains syntactical error(s), the segment(s) and elements(s) where the error(s) occurred will be reported in AAA Segments. The AAA Segments are used to report corrupt data or an invalid trading partner relationship. For more information, refer to "Segments" in the *Data Specifications Overview* section of this document.

## Guide Objective

This Companion Guide provides information about Leased-Line (LL) and CICS Inter-System Communication (ISC) 270 Eligibility Request and 271 Eligibility Response transactions that are specific to DHS trading partners. For these transactions, this guide describes the data submitted to DHS by providers and other trading partners when they make electronic eligibility requests, as well as the data sent by DHS in response. Intended users of this guide are the technical staffs of external entities that are responsible for electronic transaction/file exchanges.

## Relationship to HIPAA Implementation Guides

Companion Guides supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Detailed rules for format, content and field values can be found in the Implementation Guides. This guide describes the DHS LL and CICS ISC environment interchange conventions. It also provides specific information about the fields and values required for transactions sent to or received from DHS.

Companion Guides are intended to supplement, rather than replace, the standard HIPAA Implementation Guide for each transaction set. Information in the Companion Guide does not:

- Modify the definition, data condition or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

## New Terminology

New terminology accompanies the implementation of these new transactions. For example, a patient is now referred to as a “subscriber” rather than as a “recipient.”

Previous Word	New Word
Billed Amount	Total Claim Charge Amount
Date of Birth	Subscriber Birth Date
Date of Card Issue	Issue Date
Date of Service	Service Date
Eligibility Verification Number	Trace Number (Eligibility Verification Confirmation [EVC] Number)
First Name	Subscriber First Name
Last Name	Subscriber Last Name
MEDI Services	Medical Services Reservation
Provider Name	Information Receiver Name (Provider Name)
Provider Number	Service Provider Number
Recipient	Subscriber
Recipient ID	Subscriber ID
Scope of Coverage	Service Type (Scope of Coverage)
Share of Cost (SOC)	Spend Down Amount (SDA)

## Final Authority

The ASC X12N 270/271 (004010X092A1) Implementation Guide is used as the format standard for the 270 Eligibility Inquiry and 271 Eligibility Response.

The ASC X12N 270/271 (004010X092) Standards Guide is used as the format standard for the 270/271 Share of Cost/Spend Down and the 270/271 Share of Cost Reversal/Spend Down Reversal transaction.

The ASC X12N 270/271 (004010X092) Standards Guide is used as the format standard for the 270/271 Medical Services Reservation and the 270/271 Medical Services Reservation Reversal transaction.

**Note:** The above reference guides were used as the source for this Companion Guide.

# Third-Party Dial-Up and Leased-Line Network Transmission Protocol Instructions

Instructions for third-party dial-up and leased-line network transmission protocols are presently contained in the document *Medi-Cal Point of Service (POS) Network Interface Specifications*, which is available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov); click the “Publications” link, then the “Technical Publications” link.

However, new instructions will soon be published in a document titled *Medi-Cal POS Network Telecommunications Interface Standards*. This document will be available at the above-mentioned location on the Medi-Cal Web site.

# System Testing

## Provider/Submitter Testing Procedures

This section describes the testing procedures required by EDS to ensure accurate transaction format, completeness and validity.

Completion of the testing process is voluntary and is by invitation only, but will be available to providers and submitters during the month of September 2004 if they wish to participate. Providers and submitters who wish to test the 270/271 Eligibility transactions using the 4010A1 format should contact the Telephone Service Center (TSC) at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200) and select the prompt for POS/Internet inquiries. The provider/submitter will be contacted by an EDS software engineer, who will explain how to send the subscriber test data that should be submitted in the 270 Eligibility Inquiry transaction. Assistance from the TSC is available throughout this process seven days a week from 6 a.m. to midnight to help providers determine any errors with failed transactions.

Each failed test transmission is inspected thoroughly to determine where the format errors exist. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, Medi-Cal requests that providers send transmission data as supplied to them by EDS to the Medi-Cal test Web site (<http://sysdev.medi-cal.ca.gov>). This must be coordinated with EDS prior to testing using the previously mentioned contact information. The number of test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. The Companion Guides published on the Medi-Cal Web site must be used as the source of information that providers reference to format the 270 Eligibility Inquiry transaction and receive the 271 Eligibility Response transaction.

**Note:** Subscriber test data submitted will not be processed by the Production system. This data is for testing purposes only. However, providers should use their own provider number and password/PIN to submit the 270 Eligibility Inquiry transaction.

All other questions should be directed to the TSC at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200).

# Data Specifications Overview

## Purposes of Specifications

The purposes of the transaction specifications are to define the data elements and code set values that DHS allows between trading partners and to specify the type and format of transaction information. In some cases the values specified are subsets of the data element values listed or referenced in the Implementation Guides. In others, they are specific to DHS requirements. For example, in the Information Source Loop of a transaction in the Implementation Guide, Data Element NM109 is defined as an Identification Code between two and 80 characters long. In these transaction specifications, NM109 is defined as the DHS ETIN Number (610442) and the data-element length is from two to 15 characters.

Specifications for the 270 and 271 transactions accommodate both LL and CICS ISC transaction submissions and responses. Transaction responses with error conditions return code set values in AAA segments (i.e., rejection information).

The information in the data specifications does not: (1) modify the definition, data condition or use of any data element or segment in the standard Implementation Guides; (2) add any additional data elements or segments to the defined data set; (3) utilize any code or data values that are not valid in the standard Implementation Guides; or (4) change the meaning or intent of any implementation specifications in the standard Implementation Guides.

## General Transaction Formatting Information

The 270/271 transactions (inquiries and responses) consist of data elements that are grouped into segments, which in turn are grouped into either a heading or summary section, or grouped into loops. This grouping or nesting is different for each of the six transaction types specified in these technical specifications. The data-element groupings or structures are illustrated on page 3 of each technical specification.

## Data Elements

Data elements can be required or situational, fixed in length or variable, and are each a specified type of data element that can repeat. The usage, length, type and occurrence are all documented with each data element in the technical specifications. Along with most data elements, there are codes from which to choose (in the case of inquiries) or that will be returned (in the case of responses). Alternatively, each data element may have a “Medi-Cal Note” specifying what Medi-Cal has decided must be entered or what will be returned.

Below are the various data element format types used. More information can be referenced in the Implementation Guide, beginning on page A.4.

<b><u>Format Type</u></b>	<b><u>Symbols</u></b>
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time

### **Format Type Descriptions**

*Nn – Numeric:* The data elements may be defined to include a decimal point, which may be fixed in location (a value between 0 and 9) counting from the right designated by “n”. The decimal point is not transmitted with the data. The data is right-justified.

*R – Decimal Number:* A numeric value containing an explicit decimal point. The decimal point must appear as part of the data stream if it is located at any place other than the right-most end of the number. If a decimal point is not included in the number, none will be assumed. Do not use commas in the decimal number.

*ID – Identifier:* A specific code taken from a predefined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the committee. The ID codes that will be accepted for Medi-Cal billing are shown as literals within double quotes in the “Values” column for each data element of ID type.

*AN – String:* Any characters from the basic or extended characters set. The Basic Characters Set is defined as:

- Uppercase letters: A through Z
- Digits: 0 through 9
- Special characters: ! " & ' ( ) \* + , - . / : ; ? =
- Space character

The Extended Characters Set is defined as:

- Lowercase letters: a through z
- Special characters: % ~ @ [ ] \_ { } \ | < > # \$

At least one non-space character is required. The significant characters should be left-justified. Trailing spaces should be suppressed unless the field is fixed-length.

*DT – Date:* Used to express the standard date in either YYMMDD or CCYYMMDD format, in which CC is the first two digits of the calendar year. YY is the last two digits of the calendar year, MM is the month (01 to 12) and DD is the day in the month (01 to 31).

*TM – Time:* Used to express the ISO standard time HHMMSSd..d format, in which HH is the hour for a 24-hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds.

Where two numbers are separated by a slash (/), the first number is the minimum allowable length for the field and the second number is the maximum allowable length for the field. Where there is only one number, the length of the field is fixed. Larger fields within the ASC standards will be accepted, but will be truncated on the right if the field is alpha-numeric and on the left if the field is numeric.

## Segments

Segments can be required or situational, and they can repeat. The usage and occurrence are documented with each segment in the technical specifications. Along with each segment is an example of a data stream using the data elements within each segment. More examples can be referenced in the Implementation Guide, beginning on page 343.

### *AAA Segments*

The AAA Request Validation segment is used to identify why a response transaction has not been generated; in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically, the AAA segment is generated as a result of either an error in the data (e.g., missing Subscriber ID) or no matching information in the database (e.g., subscriber not found). One other use of the AAA segment is to identify a problem with the processing system itself (e.g., the information source’s system is down).

There are three elements used in the AAA segment. AAA01 is a yes/no indicator and identifies whether the data content was valid. AAA02 is not used. AAA03 is a Reject Reason Code and identifies why the transaction or a data element is invalid. AAA04 is a Follow-up Action Code and identifies what further action should be taken.

More information can be referenced in the Implementation Guide, beginning on page 23.

## Loops

Loops can be mandatory or optional, and can repeat. The use and occurrence are documented on each loop page in the technical specifications. Along with each loop is a list of the segments or sub-loops that comprise it.

Each loop within a transaction represents a grouping of segments pertaining to the information source (Medi-Cal), the information receiver (the provider or clearinghouse), or the subscriber. Loops are documented as loop A, B or C to represent the source, receiver or subscriber, respectively. Alternatively, the loop occurrence can be represented as: first (source), second (receiver) and third (subscriber).

## Excluded Data Elements and Segments

Data elements documented as required are only mandatory if the segment is used. If a segment is situational and is not used, then any required data elements therein are not mandatory. Those data elements are only mandatory if the segment is used.

## Complete Transaction Example

Each technical specification has examples of transaction data streams at the segment level. Below is a complete transaction data stream example for a 270 Eligibility Inquiry transaction, which is a combination of all the appropriate segments. Spaces (variable information) in the examples are represented by periods (.) for clarity.

Example:

```
ISA*03*.....*01*.....*ZZ*.....*ZZ*610442EDS214...*YYMMDD*HHMM*U*00401*.....*0*P*~(Hex'0D')GS*HS*.....*601442EDS214*CCYYMMDD*HHMMSSDD*.....*X*004010X092A1(Hex'0D')S  
T*270*.....(Hex'0D')BHT*0022*13*.....*CCYYMMDD*HHMMSSDD(Hex'0D')HL*1**2  
0*1(Hex'0D')NM1*PR*2*Medi-Cal*****46*610442EDS214(Hex'0D')HL*2*1*21*1(Hex'0D')      NM1*1P*1**  
***SV*.....(Hex'0D')HL*3*2*22*0(Hex'0D')TRN*1*.....*1.....*.....  
.....(Hex'0D')NM1*IL*1*****MI*.....(Hex'0D')REF*A6*.....(Hex'0D')DMG*D8  
*CCYYMMDD(Hex'0D')DTP*102*D8*CCYYMMDD(Hex'0D')EQ*30(Hex'0D')SE*.....*.....(Hex'0D')GE  
*1*.....(Hex'0D')IEA*2*.....(Hex'0D')
```

## Delimiters and Terminators

A delimiter is a character used to separate two data elements (or sub-elements), and a terminator is used to terminate a segment. Delimiters and terminators are integral parts of the data and are specified in the interchange header segment (ISA). They are explained on page 2 of each technical specification document.

A data-element delimiter (also referred to as a separator) will always be used after or in place of each data element. Exceptions to this are that no delimiters are used in place of trailing data elements (refer to page 2 of each technical specification document), and the last data element used is followed only by a segment terminator. The following delimiter and terminator are used in inquiry and response transaction examples:

(Hex0D) segment terminator

\* Asterisk data element delimiter/separator

~ Tilde sub-element separator (specified but not used)

## Submitter Software Versions

Submitters must enter their three-character submitter ID, followed by their four-character software version number in ISA02. Medi-Cal/DHS has the ability to deactivate certain software versions when necessary, thus rejecting transactions.

## Identification Card Standards and Check-Digit Algorithms

Each Medi-Cal or Denti-Cal subscriber receives a Benefits Identification Card (BIC), a plastic identification card that contains a three-track magnetic stripe. The BIC is used instead of the existing paper card, which is issued on a monthly basis. The magnetic-stripe format is based on standards endorsed by the American National Standards Institute (ANSI) and the International Standards Organization (ISO). New standards will soon be published in a document titled *Medi-Cal Identification Card Standards*. This document will be available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov); click the “Publications” link, then the “Technical Publications” link.

Transactions sent through the Medi-Cal POS system will contain the Beneficiary Identification (BID), the Medi-Cal Eligibility Determination System (MEDS) ID or the Client Index Number (CIN). Internal to the transaction-generation software is the subscriber ID check-digit calculation, which can be used to verify the accuracy of an ID that includes the check digit (i.e., 15-digit BID or 10-digit SSN, MEDS or CIN). The CIN uses the same check-digit algorithm as the MEDS ID. More information about these algorithms is contained in the document *Check Digit Algorithms*, which supplements this companion guide.

## Provider Mail

Within the Interchange Control Transmission (between the ISA and IEA segments) are functional groups. For an inquiry, there will be only one functional group, the HS group, which contains the 270 Inquiry transaction. However, for a response there will always be two functional groups: HB (response), which contains the 271 Response transaction, and TX (provider mail), which contains the 864 Provider Mail transaction.

A Provider Mail transaction will always be returned with system messages, and one such message will always be the System Down Time.

The layout for the TX/864 functional group or transaction set is contained in the document *Provider Mail: TX Functional Group or 864 Transaction Set*, which supplements this Companion Guide.

# Appendix A: AAA Segment Error Processor Table

The following table describes errors that may be detected in inbound 270 X12 4010 transactions and the level at which they occurs. The AAA segment(s) are returned in the outbound 271 transaction when appropriate.

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
2000A	ISA06 Provider number not found, or not present, or is inactive, or has an invalid PIN.	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	41: Authorization/ Access Restrictions
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C or N
	ISA08 ETIN is not 610442	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C or N
	System problem	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	42: Unable to Respond at Current Time
		AAA04	P: Please Resubmit Original Transaction Or R: Resubmission Allowed	P or R
2100A	NM101 is not 1P	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	T4: Payer Name or Identifier Missing
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	NM108 is not 46	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C or N
	NM109 does not contain 610442	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C or N
	System not available	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	42: HAP System Unavailable or Spend Down (SOC) System Not Available
		AAA04	R: Resubmit	R
2100B	NM101 is not 1P	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
	NM108 is not SV	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	43: Invalid/Missing Provider Identification
	NM109 is not present	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	48: Invalid/Missing Provider Identification Number
	NM109 is present but not on file	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	51: Provider Not on File
	NM109 is present and on file but is not active	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	41: Authorization/ Access Restrictions
	2100C NM101 is not PR	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C or N
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	64: Invalid/Missing Patient ID
2100C	NM108 is not MI	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	64: Invalid/Missing Patient ID
	NM109 is not present	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	15: Required Application Data Missing
	NM109 not Found	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	75: Subscriber ID Not Found
	DMG01	AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
		AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
	is not D8	AAA03	Reject Reason Code	56: Inappropriate Date
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	DMG02 is not a valid date	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	58: Invalid/Missing Date of Birth
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	DTP01 is not 102 or 472	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	15: Required Application data Missing
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	DTP02 Is not D8	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	56: Inappropriate Date
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	DTP03 Is not a valid date	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	57: Invalid Missing Date of Service Or 15: Required Application Data Missing
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
2110C	AMT01 Is not R or PB for Spend Down	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	54: Inappropriate Product/Service ID Qualifier
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	AMT02 Is not a dollar amount for Spend Down	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	15: Required Application Data Missing
		AAA04	C: Please Correct and Resubmit Or N: Resubmission Not Allowed	C
	DTP01 is not 102, 307, 458 or 472	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	57: Service Date Invalid
		AAA04	C: Please Correct and Resubmit	C

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
	DTP02 Is not D8 or RD8	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	62: Service Date out of range
		AAA04	C: Please Correct and Resubmit	C
	DTP03 Is not a valid date	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	56: Issue date Invalid
		AAA04	C: Please Correct and Resubmit	C
	NM109 Invalid code	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	72: Invalid HAP or BIC ID
		AAA04	C: Please Correct and Resubmit	C